Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: COMPREHENSIVE PAIN MANAGEMENT 5734 SPOHN DRIVE STE. A CORPUS CHRISTI, TX 78414	MFDR Tracking #: M4-10-2037-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: AMERICAN HOME ASSURANCE CO Box #: 19	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as taken from the Table of Disputed Services: "Physician saw the patient for an office visit for his compensable injury. According to TWCC Fast Facts, if the injury is compensable, the carrier is liable for all reasonable and necessary medical costs of health care to treat the compensable injury. Carrier failed to respond to the original request for payment. Carrier also failed to responsd {sic} to the request for reconsideration (see attached proof of delivery for all request {sic}.

Amount in Dispute: $78.14

PART III: RESPONDENT'S POSITION SUMMARY

The Respondent did not respond to this dispute.

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
12/17/08	99213	52.83 ÷ 38.087 x $56.34 = $78.15	$78.14	$78.14
			Total Due:	$78.14

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.240 sets out the guidelines for medical payments and denials.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   No explanation of benefits were submitted in this dispute.

Issues

1. Did the insurance carrier pay or deny the bill for date of service 12/17/08?
2. Did the requestor submit proof that the medical bill was submitted to the carrier for processing?
3. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to rule §133.240(a) An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation. The requestor did not submit any EOB's in this dispute.
2. A copy of the requestor's letter of reconsideration to the carrier dated 5/4/09 asking the insurance carrier to take final action on the claim is submitted. A claims mail log is attached supporting confirmation the reconsideration was sent on 5/18/09. A certified returned mail receipt is attached which is addressed to Claimetrics and signed which supports the Carrier received the bill. Although the requestor did not submit proof of the original first submission of the bill to the carrier, the requestor has met the burden of proof with supporting documentation that the reconsideration bill was received by the carrier and the carrier has not responded. In addition, the Respondent did not submit a response to this dispute. Therefore, reimbursement for CPT code 99213 is recommended. The MAR amount for CPT code 99213 is $78.15. However, the requestor is only seeking $78.14.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $78.14.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $78.14 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	**12/14/10** Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.